Affidavit of Jennifer J. Carroll, Ph.D., M.P.H., M.A.

I, Jennifer J. Carroll, Ph.D., M.P.H., M.A., declare and state as follows:

1. I am a medical anthropologist and public health scientist specializing in substance use and the impact of individual- and policy-level interventions on the public health risks posed by substance use. I completed my undergraduate studies at Reed College, graduate studies in sociology at Central European University, graduate studies in cultural anthropology and epidemiology at the University of Washington, and post-doctoral training in clinical research and infectious disease at Brown University School of Medicine.
2. Currently, I am an Assistant Professor of Anthropology, with promotion to Associate Professor of Anthropology with tenure effective August 15, 2024, at North Carolina State University. Concurrently, I hold an appointment as an Adjunct Assistant Professor of Medicine at Warren Alpert Medical School at Brown University. My research agenda in the United States focuses on substance use behaviors, novel interventions to reduce overdose mortality in the context of a rapidly changing illicit drug supply, and the public health and public safety impacts of policy-level responses to substance use ranging from syringe access laws to criminal drug enforcement.
3. Since 2018, I have been retained by the National Center for Injury Control and Prevention at the U.S. Centers for Disease Control and Prevention (CDC), via interagency personnel agreement (IPA) with my primary university, as a subject matter expert on overdose and other harms associated with substance use. Prior to this IPA, I worked full time with the Atlanta/Carolinas High Intensity Drug Trafficking Area (HIDTA) as the primary scientific lead, seated in the National Center for Injury Prevention and Control, with the Overdose Response Strategy, a coordinated partnership between the CDC and the HIDTAs intended to prevent overdose through innovative public health/public safety collaboration.
4. In my capacity as a scientist and subject matter expert serving the CDC, I have written numerous official guidelines and technical packages published by the CDC on overdose and overdose prevention strategies, including *Evidence-Based Strategies for Preventing Opioid Overdose: What’s Working in the United States* (2018), *Linking People with Opioid Use Disorder to Medication Treatment: A Resource for Action of Policy, Programs, and Practices* (2022), and *Division of Overdose Prevention Stimulant Guide: Answers to Emerging Questions about Stimulants in the Context of the Overdose Epidemic in the United States* (2024).
5. I am the author or co-author of more than 50 peer reviewed research articles in the area of substance use and public health, which, collectively, have been cited nearly 1,200 times in the last 5 years alone. I was the lead author on the first systematic investigation of the experiences and responses of people who use drugs to the emergence of fentanyl in the U.S. drug supply.[[1]](#footnote-1) I was the lead author on the first systematic investigation of emergent public health strategies to reduce the harms or xylazine contamination in the U.S. drug supply.[[2]](#footnote-2) I was also the lead author on the first study to empirically document the meaningful role that stable drug suppliers play in protecting people who use drugs against overdose (and, in turn, the excess overdose risk that people who use drugs are exposed to if their stable drug supplier is arrested)[[3]](#footnote-3) and a co-author on the first study to identify statistically significant increases in fatal and non-fatal overdose as a consequence of drug seizures by law enforcement.[[4]](#footnote-4)
6. I am, to the best of my knowledge, one of two public health scientists in the United States who are proactively researching the public health consequences of laws that create criminal liability for an accidental drug overdose equivalent to manslaughter or homicide (such as RCW 69.50.415), often referred to as controlled substance homicide, drug-induced homicide, or death by distribution laws (henceforth “controlled substance homicide laws”). The other scientist proactively working in this area is Taleed El-Sabawi, J.D., Ph.D.
7. Below, I present information based on my own research and other bodies of scientific evidence that leads me to conclude that: (1) controlled substance homicide laws are inequitably enforced and charges brought under these laws represent extreme racial bias; (2) prosecutors who file controlled substance homicide charges are often motivated by false beliefs about the public health benefits such laws that are not supported by any systematic or scientific evidence; (3) controlled substance homicide laws undermine the effects of state 911 Good Samaritan Laws, which are well-tested and well-proven policy-level overdose-prevention strategies; (4) controlled substance homicide laws and charges brought under those laws increase the risk of overdose in the surrounding community; and (5) the premise that drug suppliers and people who use drugs are distinct populations analogous to “exploiters” and “exploited victims” is false, does not reflect the realities of substance use in a criminalized market, and causes excess harm against people who use drugs, including excess overdose.
8. I was the lead investigator of a nation-wide survey of criminal defense attorneys who have defended clients against charges of controlled substance homicides (or their state-specific equivalents) following the accidental drug overdose of another person. Data was collected from defense attorneys in 31 U.S. states, including Washington state. Preliminary findings indicate that 26% of the individuals these attorneys defended against controlled substance homicide charges were Black, and 55% were non-Hispanic white.[[5]](#footnote-5) This pattern of inequity is similar to the rate of over-arrest and over-prosecution of Black Americans, who comprise only 12% of the U.S. population, for any drug-related crime.[[6]](#footnote-6)
9. An even greater racial disparity emerges when the race of the overdose victim, whose death prompted a controlled substance homicide charge, is considered. In my survey, 90% of defense attorneys reported that the decedent whose death prompted their most recent controlled substances homicide case was white.[[7]](#footnote-7) This finding aligns with the conclusions of a media analysis conducted in 2019 by the Health InJustice Action Lab at Northeastern University, which found that 100% of decedents who were neither a close friend nor family member of the person charged with controlled substances homicide in connection with their overdose death were white.[[8]](#footnote-8) Put bluntly, controlled substance homicide charges are almost exclusively brought in response to the death of a white person—the result of systemic racism that rewards the criminal justice system for placing a higher value on white lives and pursuing harsher criminal punishments for alleged injustices suffered by white Americans.[[9]](#footnote-9)
10. I am the lead researcher and senior author of an article titled *Prosecuting overdose: An Exploratory Study of Prosecutorial Motivations for Drug-Induced Homicide Prosecutions in North Carolina*, which details survey data collected in 2021 and 2022 from North Carolina prosecutors about their experience with and perceptions of North Carolina’s controlled substance homicide law (GS 14-18.4).[[10]](#footnote-10) This study found that most prosecutors believe that prosecutions and convictions under this law will deter substance use, drug distribution, fentanyl distribution, and other drug-related crimes in their district and are motivated by these beliefs to file criminal charges under this law following fatal overdose events.[[11]](#footnote-11) There is no scientific evidence that supports these beliefs either in principle or in fact. Indeed, for years, the scientific consensus in the field of criminology has held that enhanced criminal punishment (which controlled substance homicide laws represent) has no deterrent effect on criminal behavior.[[12]](#footnote-12)
11. This study of North Carolina prosecutors also demonstrated that the number of controlled substance homicide cases brought in North Carolina prosecutorial districts since 2018 has no statistical relationship with the rate of overdose deaths in each district, respectively.[[13]](#footnote-13)
12. Overwhelming scientific evidence suggests that deterrence through criminal punishment largely reshapes how, not whether, actors participate in the illicit drug market, often producing harmful secondary effects by promoting behavior changes that have deleterious effects on community health such as increased HIV risk[[14]](#footnote-14) and risk of other drug-related harms among people who use drugs.[[15]](#footnote-15)
13. State 911 Good Samaritan Laws, which confer limited immunity for certain drug-related offenses discovered because 911 was called to report an overdose emergency, are an evidence-based overdose prevention strategy,[[16]](#footnote-16) with some studies estimating that effectively implemented 911 Good Samaritan Laws can reduce state-wide opioid overdose deaths by as much as 10-15% facilitating help-seeking during a potentially deadly emergency.[[17]](#footnote-17)
14. Multiple studies have documented that controlled substance homicide laws reduce the likelihood that a bystander will call 911 to report an overdose by increasing the perceived risk of arrest if first responders are dispatched to the scene. This finding has been reproduced in Maryland,[[18]](#footnote-18) North Carolina,[[19]](#footnote-19) Pennsylvania,[[20]](#footnote-20) Rhode Island,[[21]](#footnote-21) and West Virginia.[[22]](#footnote-22)
15. Washington state’s 911 Good Samaritan Law (RCW 69.50.315) does not confer immunity from criminal charges brought under RCW 69.50.450, placing these two laws in conflict and directly undermining the life-saving impacts of RCW 69.50.315.
16. I am the lead author of a paper titled *Drug-Induced Homicide Laws May Worsen Opioid-Related Harms,* which documents community-level impacts of controlled substance homicide prosecutions other than deterring calling 911 during a suspected overdose emergency. This study documented several mechanisms by which such a prosecution in North Carolina increased overdose risk in the surrounding community, including triggering unpredictable fluctuations in the local drug supply.[[23]](#footnote-23) This increased the risk of overdose by reducing the ability of people who use drugs to properly assess and consume a therapeutically appropriate dose (i.e. to not over-dose) by rendering the drug supply more varied, less predictable, and deadlier as a result.
17. The above article also provided evidence that social proximity to (i.e. closer friendship with) a person prosecuted for controlled substance homicide increases the laws deterrence effect against calling 911 in the event of a potentially fatal overdose emergency.[[24]](#footnote-24) This finding aligns with the conclusions of another study conducted in Anne Arundel County, MD, which found that knowing of someone charged with a controlled substance homicide predicts 2.6-times higher odds of perceived vulnerability to arrest in the event that law enforcement responds to an overdose.[[25]](#footnote-25)
18. I am the lead author on a paper titled *The Protective Effect of Trusted Dealers Against Opioid Overdose in the U.S.,* which presents findings from extended interviews with people who use illicit opioids in harm reduction service settings and in the hospital emergency department following a non-fatal overdose emergency. Half of the individuals I interviewed post-overdose in the emergency department were regular (daily or near daily) consumers of illicit opioids (typically heroin and/or fentanyl-contaminated heroin). Of those individuals who reported regular use, 100% attributed their accidental overdose to the fact that they could not locate their regular supplier and had to seek out opioids from a secondary, tertiary, or otherwise less familiar source.[[26]](#footnote-26) One individual explained that, “it’s always more dangerous to go to your number two guy,” because that “number two guy” has a supply that you are less familiar with and has had less opportunity to develop a shared understanding with you about the relative potency and adulteration of different opioid products or batches, all of which increase the opportunity for mis-judging an appropriate dose and potentially deadly overdose. A direct extrapolation from this finding is that arresting a drug supplier immediately (and sometimes durably) places all that supplier’s clients at higher risk of overdose.
19. This pattern—that drug arrests cause drug overdoses—has been observed and reported by first responders as well.[[27]](#footnote-27) Indeed, an entire federal program, the CDC’s Opioid Rapid Response Program, was developed to mitigate the known harms of disrupting patient access to prescription opioids following law enforcement action against a prescriber, including increased risk of overdose among patients.[[28]](#footnote-28)
20. My research, presented in *The Protective Effect of Trusted Dealers Against Opioid Overdose in the U.S.,* also documented the lengths that many drug suppliers will go to in order to reduce the risk of harm to their clients—something that has been well documented in other studies and has been long understood and leveraged to the benefit of public health by harm reduction organizations. My research documented suppliers reaching out to clients when they discovered their heroin supply to be contaminated with fentanyl as well as suppliers facilitating naloxone access among their network—sometimes in the immediate and at risk to themselves in order to save a life.[[29]](#footnote-29) Other studies, including one that I presented in a paper entitled *The Bronze Age of Drug Checking*, have provided evidence that drug suppliers are among the most likely to participate in community-based drug checking services in order to gain insight into the contents of their drug supply and provide potentially life-saving information about that supply to their clients.[[30]](#footnote-30) These studies have documented how, when receiving unexpected results, such as learning that their opioid supply contains xylazine or synthetic cannabinoids (both of which can cause unpredictable harm to opioid consumer), suppliers regularly warn consumers about the adulteration, negotiate with mid-level suppliers to receive safer opioid products, and even toss out contaminated batches at a personal loss.[[31]](#footnote-31) While these activities cannot prevent all overdoses, removing stable suppliers from the drug market through arrest or prosecution, including prosecution under controlled substances homicide laws, removes these key protections and meaningfully increases overdose risk among all those who had relied upon them.
21. Many people who supply drugs are also people who use drugs—not people who are selling drugs for the purpose of running a business or seeking a profit. In the spring of 2024, I have been conducting a new study measuring the amount of variability in opioid supply that regular (daily or near daily) opioid consumers are exposed to under normal circumstances. Preliminary findings from this study indicate that people who are not supplying drugs for profit may actually be at greater risk of experiencing an overdose in their social network, and thus be at greater risk of controlled substance homicide charges, despite the fact that they in no way represent the “king pin” figure that many controlled substance homicide laws are intended to target.[[32]](#footnote-32) Participants in this study who have long-term, trusted, stable suppliers consistently obtain opioid products of predictable potency, free of adulterants like xylazine, isotonitazine, and other concerning substances. Participants in this study who have lost access to a stable supplier in the past year (typically as a result of that supplier being arrested for drug distribution) have not yet been able to forge trusting relationships with new suppliers and continue to rely on friends and relatives to purchase opioids on their behalf. Consequently, these participants are more likely to be exposed to opioid products of wildly varied potency and adulterants ranging from xylazine, erythritol, acetaminophen, lidocaine, and even methamphetamine. These individuals are at much higher risk of overdose due to their inability to access a reliably stable supply of opioids, thus placing their friends and family members, who are also people who use drugs, likely with un- or under-treated substance use disorders and other mental health disorders, at greater risk of prosecution should they experience an accidental overdose.
22. My nationwide survey of defense attorneys similarly found that nearly half of all defendants charged with a controlled substance homicide are a close friend, family member, or romantic partner of the individual who suffered a fatal overdose.[[33]](#footnote-33) Similarly, findings from the media analysis conducted by the Health InJustice Action Lab at Northeastern University support this contention, finding that 50% of all controlled substance homicide cases identified in the media represent the prosecution of a friend, family member, caretaker, or romantic partner of the individual who suffered a fatal overdose—not a “king pin” dealer.[[34]](#footnote-34)

I declare under penalty of perjury that the foregoing is true and correct to the best of my knowledge and belief. Executed on June 11, 2024

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Jennifer J. Carroll, Ph.D., M.P.H., M.A.

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